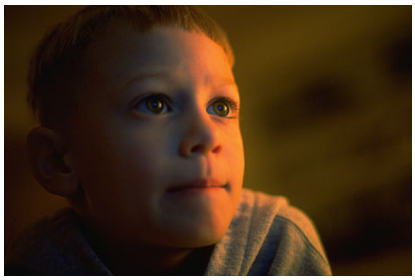


Department of Health
Child and Adolescent Mental Health Division

Sustainability Report

Performance Period October 2002-March 2003

Introduction

This report presents information about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD) during the second and third quarters of fiscal year 2003 (October 2002-March 2003). A key change in data presentation has been made as compared to the first quarter's (July-September 2002) report. In efforts to present the timely information needed to assess sustainability efforts, this report presents the most current data available. Where possible, data are aggregated at both statewide and district or complex levels.

Data, as in the first quarter report, are presented in four major areas: Population, Service, Cost, and Performance. Population information describes the characteristics of the children, youth, and families that are served. Service information is compiled regarding the type and amount of direct care services that are used by children, youth, and families. Cost information is gathered about the financial aspects of services. Performance information, including Outcome data, are collected to track and understand the quality of services and the performance of operations of the statewide infrastructure needed to provide supports for children, youth, and families. Outcomes are further examined to determine the extent to which services provided lead to improvements in the functioning and satisfaction of children, youth and families. Improvement strategies to address issues identified through this report are offered in the summary section.

This comprehensive data set is used both internally by CAMHD to make decisions about services, and to allow all CAMHD stakeholders to view the core aspects of service delivery and performance of the mental health service system for children, youth and families. A primary use of data is to inform continuous improvement efforts at all levels.

Data Sources and Uses

Because of the wealth of information that is now available, CAMHD's Executive Management Team and the Performance Improvement Steering Committee (PISC) are able to continually review information about the quality and effectiveness of care across the service system. Performance reporting about client status, care and service delivery is assessed to determine priorities for improvement, including areas that would benefit from focused study. The PISC also monitors and evaluates actions taken to improve performance.

The primary source for data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental

Health Management Information System (CAMHMIS). CAMHMIS has the ability to produce data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level. Client-specific and aggregate reports are used by staff at all levels. Family Guidance Center (FGC) Branch Chiefs and supervisors are able to access timely data relevant to center and staff performance. Local-level managers are also able to monitor FGC and statewide trends and performance expectations, which further supports planning and decisions.

CAMHMIS has multiple features, including the ability to generate "live" client and FGC-specific reports. During the second and third quarters of fiscal year 2003, CAMHD has begun implementing a clinical reporting module in the Family Guidance Centers throughout the state. This new reporting system presents comprehensive caseload summaries and individual client histories of information available in CAMHMIS. These reports provide the FGCs with access to daily registration, authorization, billing, and outcome information for every day that youth have been enrolled in CAMHMIS. The implementation of this system has been integrated with the ongoing development of supervision practices. Installation and training on the new module was completed at the Central Oahu, Hawaii, Honolulu Oahu, and Maui FGC as of March 31, 2003. The remainder of the FGCs are scheduled for completion by May 2003.

Changes to the Current Report

The previous quarterly report presented actual cost and service information, which was based on adjudicated claims. These data are available at the end of the following quarter in which services were delivered (or a quarter in "arrears"). Thus, the last quarterly Sustainability Report, published in February 2003, represented data from the first quarter of the fiscal year. The key change in this report is that data are presented for the most recently closed quarter, in this case the third quarter of fiscal year 2003. In order to present up-to-date information, service data are no longer based on services received, but on services authorized. In most cases, service authorization data are very similar, but may not be identical to actual utilization data. Cost data are based on actual billing and are, by necessity, reported 90 days in arrears. Additionally, population data and performance measures are aligned with reporting for the third quarter (January-March 2003), and data for the second quarter are not highlighted in this report.

Population Characteristics

Population data reflect the third quarter of fiscal year 2003 (January-March 2003) for youth registered in the CAMHD Family Guidance Centers. In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,752 youth across the State, a decrease of 737 over the first quarter, and 18 over the second quarter. The decline is largely attributed to the discharge of youth with Pervasive Developmental Disorders during the first quarter who now receive services through the Department of Education.

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through

Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There was also a small percentage of youth who received case management services only. Of the total registered youth, 921 had services that were authorized within the quarter.

Of the registered population 134 youth (7.6%) were newly registered. This represents 63 more new admissions than the first quarter. One hundred fifty-three (153) youth (8.7%) who had previously received services from CAMHD were reregistered in CAMHMIS. CAMHD discharged a total of 236 youth during the quarter or 13.5% of the registered population. This compares to the first quarter's discharge of 36.9% of the registered population, which again was mostly attributed to youth who were transferred to the Department of Education or the Developmental Disabilities Division with pervasive developmental disorders. Of the 921 youth who had services authorized in the quarter, 51 received a new admissions (5.5%), 72 a repeat admissions and 76 a discharge (7.9%). There were 25 more youth with discharges than admissions in the period. It is important to note that because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth registered in the reporting quarter was 14 years with a range from 3 to 19 years. As displayed in Table 1, the majority of the youth were male (68%), which is fairly typical of populations served through public mental health systems.

Table 1. Gender of CAMHD Youth

Gender	N	% of Available
Females	564	32%
Males	1,188	68%

Table 2 describes the various ethnicities of youth who received authorizations for services in the reporting quarter. Those with Mixed ethnicities represented the largest group (26.8%), closely followed by youth of Hawaiian ethnicity (26%). Caucasian made up the third largest ethnic group (21.9%), followed by Filipino (7.6%) and Japanese (4.2%).

Table 2. Ethnicity of Youth with Authorized Services

Ethnicity	N	% of Available
African-American	21	2.0%
African, Other	2	0.2%
American Indian	4	0.4%
Asian, Other	10	0.9%
Caucasian, Other	232	21.9%
Chamorro	0	0.0%
Chinese	3	0.3%
Filipino	81	7.6%
Hawaiian	275	26.0%
Hispanic, Other	10	0.9%
Japanese	44	4.2%
Korean	2	0.2%
Micronesian	4	0.4%
Mixed	284	26.8%
Pacific Islander	18	1.7%
Portuguese	29	2.7%
Puerto Rican	9	0.8%
Samoan	31	2.9%
Not Available	693	39.6%

CAMHD youth may also have involvement by other public child-serving agencies including the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, or are QUEST-eligible (see Table 3). Of the youth who had services authorized in the quarter, 15.9% were involved with DHS, 30.5% had a Family Court hearing during the quarter, and 10.2% were incarcerated at HYCF or the Detention Home. QUEST-eligible youth represented approximately 30% of the CAMHD population. CAMHD continues to receive Federal Medicaid reimbursement for services provided per a Memorandum of Agreement (MOA) with the MedQuest Division of the Department of Human Services. A key provision of the MOA now allows QUEST-eligible youth with Severe Emotional and Behavioral Disturbance who may not have an IEP or 504 Modification Plan to receive services through CAMHD. The Quest Health plans, child-serving agencies or other referral sources may refer youth directly to CAMHD for a determination of eligibility for intensive mental health services.

Table 3. Agency Involvement of Youth with Authorized Services

Agency Involvement	N	%
DHS	146	15.9%
Court	281	30.5%
Incarcerated	94	10.2%
Quest	275	29.9%

Table 4. Diagnostic Distribution of Youth with Authorized Services

Any Diagnosis of	N	%
Mood	236	25.6%
Disruptive Behavior	233	25.3%
Attentional	204	22.1%
Anxiety	80	8.7%
Miscellaneous	73	7.9%
Adjustment	67	7.3%
Substance-Related	35	3.8%
Mental Retardation	26	2.8%
None Recorded	15	1.6%
Pervasive Developmental	2	0.2%
Deferred	0	0.0%

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 4). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with procured services in the quarter were mood disorders (25.6%), disruptive behavior disorders (25.3%), and attentional disorders (22.1%).

Services

The tracking and analysis of services that are provided is a vital function in any service system for a number of reasons. Tracking of utilization of the services within the CAMHD array allows for accurate accounting and data-driven planning and decision-making. Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. On the case level, service data are constantly reviewed

to provide services based on child and family needs and within the least restrictive environment.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured, and through the Clinical Services Office database of daily census information for strategically identified services. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated it is not possible to present actual utilization for the reporting quarter (January-March 2003). Therefore, service authorization data are presented here which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, nearly two-thirds of the youth served received either Intensive In-home services (46.3%) or Multisystemic Therapy (18%). The majority of youth in an out-of-home setting received services in a Community-based Residential program (16.3%). Youth receiving treatment while in Therapeutic Family Homes accounted for 15% of those served, and Therapeutic Group Homes 10.6%. Flex services were provided for 17.8% of youth served. Considerably fewer families received Respite services compared to the first quarter (15.5%) as only 1.8% of the served population accessed this service in the reporting quarter.

Table 5. Service Authorization Summary (January 1, 2003-March 31, 2003).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	8	9	0.5%	1.0%
Hospital Residential	20	31	1.8%	3.4%
Community High Risk	11	12	0.7%	1.3%
Community Residential	113	150	8.6%	16.3%
Therapeutic Group Home	73	98	5.6%	10.6%
Therapeutic Family Home	115	138	7.9%	15.0%
Respite Home	0	0	0.0%	0.0%
Intensive Day Stabilization	1	3	0.2%	0.3%
Multisystemic Therapy	123	166	9.5%	18.0%
Intensive In-Home	334	426	24.3%	46.3%
Flex	102	164	9.4%	17.8%
Respite	12	17	1.0%	1.8%
Less Intensive	6	12	0.7%	1.3%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the second quarter of fiscal year 2003 (October 1, 2002- December 31, 2002). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 6. Out-of home residential treatment services in Hawaii, including hospital-based residential treatment accounted for 84% of expenditures. This compares to out-of home service accounting for 82.4% of the total costs in the first quarter or a 1.6% decrease in percentage of total expenditures. Youth in out-of-state treatment settings accounted for only 0.9% of total expenditures. The total cost and cost per youth in this category decreased over the previous quarter due to youth returning to Hawaii.

Table 6. Cost of Services

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	% of LOC Total ($)[b]
Out-of-State	141,265	23,544	139,534	1.5%
Hospital Residential	1,119,013	32,912	796,250	8.5%
Community High Risk	467,202	42,473	436,095	4.7%
Community Residential	3,873,364	26,349	3,457,501	36.9%
Therapeutic Group Home	1,776,182	21,928	1,455,358	15.5%
Therapeutic Family Home	1,983,127	14,911	1,724,659	18.4%
Respite Home	0	0	0	0
Intensive Day Stabilization	7,226	3,613	3,250	0.03%
Multisystemic Therapy	971,118	5,365	569,799	6.1%
Intensive In-Home	1,536,140	4,000	564,882	6.0%
Flex	3,155,370	21,912	170,958	1.8%
Respite	82,395	2,943	16,628	0.2%
Less Intensive	273,348	17,084	33,005	0.4%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care. [b] Cost per LOC represents unduplicated cost for services at the specified level of care.

The greatest increase in total out-of-home expenditures and cost per youth over the previous quarter was for youth receiving treatment in hospital-based residential programs. The greatest decrease was in community-based residential services due to slightly lower utilization and lengths of stay over the previous quarter. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk

Program at some point during the quarter continued to have had the highest total cost per youth ($42,473 per youth). For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($14,911).

In-home (Intensive In-home and MST) and less intensive services accounted for 12.5% of the total cost of services. Cost patterns for in-home service showed increased expenditures on MST and decreased expenditures on intensive in-home services. Youth receiving In-home services at some point during the quarter cost an average of $4,000 per youth, which is significantly less than the cost per any youth in a residential program. Youth who received Flex services during the quarter had a cost of $21,912 per youth. Flex services may include out-of home services for some youth. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Health's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and family guidance centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youth with mental retardation and/or developmental disabilities who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD so that youth could be provided with the appropriate individualized supports consistent with national best practices in developmental disabilities.

CAMHD monitors the provision of services by DDD to youth identified in the MOA. CAMHD receives a reporting based on request for accounting of expenditures and results of service for each youth. Reporting on oversight for subcontractors of service by the DDD is also requested. Data was recently received based on requested information, and preliminary analysis has been conducted. As with all receipt of monitoring information from contractors, CAMHD conducts a systematic review of data received to determine the adequacy of service delivery. CAMHD will conduct an in-depth fiscal and programmatic review of key aspects of service delivery over the next quarter, including a joint case-based review of a sample of youth receiving residential services.

A total of $2,416,310 was transferred to DDD for the provision of respite and residential services. This total does not include personnel costs for transferred positions. Of this amount DDD budgeted $362,000 for respite. In the first three quarters of the fiscal year, $198,945 has been expended. To provide residential services, DDD entered into a

contract with Child and Family Services for $1.2 million. In the first three quarters, $1,048,452 has been expended including some funds expended prior to the execution of the service contract. DDD's expenditures under this contract total $349,484 per quarter. Projections based on the expenditure pattern are that all budgeted funds will be expended before the end of the fourth quarter due to unexpected costs. DDD intends to execute a contract modification to address service costs over budget. Total expenditures to date are $1,247,397.

Respite Services

The population eligible to receive respite services in the MOA was originally identified at 205 youth. Eligibility for the original target population was defined as having documentation of need, or utilization of respite services through CAMHD. Eight additional youth were identified as eligible through informational meetings that were subsequently held. Following the transfer of responsibilities for the administration of these funds, DDD further looked for documentation to support the need. Of the original 205 youth, 117 families or 56% were identified by DDD as eligible and in a position to receive respite supports.

Explanation of the 91 families who did not receive respite is as follows: DDD reporting indicates that of the original target group, 18% or 31 youth were not authorized to receive the services as no documentation was found on their Coordinated Service Plan (CSP) or Individualized Educational Program (IEP). Twenty-two families (10%) were mailed certified letters, but did not respond and 15 (7%) declined respite. The remaining families who did not receive the service were reported to have moved out of the state (3% or 6 families), did not pursue the application (1% or 2 families), were listed twice on the MOA or are pending proof of documentation (1% or 2 families). An additional five youth (2%) have aged out of DOE services, and six (3%) are now in a foster placement with respite service delivery pending contact with guardians.

Of the 125 families (117 families plus the 8 later identified) described above as eligible to receive respite, 91% have received the service. Twelve families or 9.4% have not received any respite reimbursements. DDD reports efforts by case managers to contact families, and is sending certified letters to families regarding the available service.

Twenty-eight of the youth who were connected with the DDD through the MOA have been admitted to the Home and Community Based Services Waiver (HCBS-DD/MR) as they meet level of care and Medicaid eligibility. Services offered under the waiver include personal assistance, habilitation, habilitation supported employment, respite, skilled nursing, environmental adaptation, transportation, specialized services and adult day health.

Data indicate that the largest percentage of respite funds is used to serve the largest target population for youth, on the island of O'ahu. Expenditures by island also indicate that Kauai has the highest respite expenditures for the fewest number of youth (11), with respite reimbursements ranging from $500.00 to $9,216.00 per child. A decline in the expenditure of respite funds was noted in the 3rd quarter as evidenced by a decrease in the spending from $77,155.25 in the 2nd quarter to $48,208.50 in the 3rd quarter of FY 2003.

Table 7. Expenditures to Date for Respite Services by Island

Island	# of Youth Served	% of Total Youth	Total Cost per Island	% of Total Dollars Expended	Average Cost per Youth
Oahu	71	56%	$90,850.00	46%	$1,279.00
Hawaii	33	26%	$58,235.00	29%	$1,765.00
Kauai	11	9%	$31,301.75	16%	$2,846.00
Maui	11	9%	$18,558.00	9%	$1,687.00

Case managers and the DDD Respite Program Coordinator monitor respite services. A satisfaction survey was recently completed. Of the responding families, 90% reported youth to be doing well overall as measured by regular school attendance, satisfactory community access, and diminishing crises. They also reported satisfaction with reimbursement procedures and opportunity for temporary breaks. One family reported dissatisfaction with reimbursement procedures, preferring direct payment to the provider.

Residential Services

Thirteen youth were originally identified in the target population as receiving community-based residential services. These youth have received services through a DDD contract with Child and Family Service for Individualized Community Residential Supports (ICRS). The funding amount of $1.2 million includes an administrative cost of 25% and a daily rate of $190.00/day.

Seven (7) of the 13 youth, or 54% of the target population, were served on the island of O'ahu, 5 youth, or 38%, on Hawaii, and 1 youth, or 8%, on Maui. The majority of the youth were living in a foster home (5 of 13), three (3) in a special treatment facility, one (1) is currently in a respite home, one (1) in a hospital-based residential setting, one (1) in an independent living home, one (who has aged out) returned to the natural family, and one (who has aged out) is living independently in a boarding home situation.

Out of the 11 youth currently being served, 7 have remained in the same placement since the execution of the ICRS contract on 07/01/02. Changes in placement occurred for the remaining 4 youth. Placement changes ranged from one to five times for the four youth and occurred for a variety of reasons including loss of foster placement, need for heightened supervision, and parental request for change in placement. The average number of placements for the 11 youth is 1.81 placements since the execution of the ICRS contract. The range of services offered in the various residential programs include room and board, supervision, coordination/linkage with DDD, DOE, and families, skills trainers, individual therapy, medication management and nutritional consultation and oversight.

Case management services are provided to the 13 (11 youth +2 adults) through DDD. In addition, case managers have admitted eligible individuals to the Home and Community Based Services-DD/MR Waiver (HCBS - DD/MR) who meet level of care and Medicaid eligibility. Out of the 13 youth served in the contract, 9, or 70%, have been admitted to the waiver. The average amount of hours of waiver supports per youth per week is 86 hours. Indicators for youth served in the contract show that: 100% had reports of improved functioning. Ten out of 11, or 91%, of the youth attend school.

Overall Supports for the Population

The CAMHD-DDD MOA moved positions and funds to DDD to serve the eligible population. Included were positions to provide planning, consultation and supports for youth with Pervasive Developmental Disabilities. Assessment of the needs of the population has resulted in an agreement with the DDD and Kapiolani Medical Center. The Agreement of Services, began on April 1, 2003 commences a collaboration to accomplish the following: 1) Define health outcomes for individuals with developmental disabilities/mental retardation including assisting in community discussions on the definition of health outcomes for individuals with DD/MR and providing independent consultation on particular issues of health and well being as raised by advocacy agencies; 2) Provide opportunities for the development of a "medical home" concept for individuals with DD/MR including consultation and education/training by DOH/DDD case managers and medical students from the John A. Burns School of Medicine and Consultation with parents and individuals with DD/MR, particularly to address transition issues; 3) Provide consultation to DOH-DDD staff statewide on medical/health issues facing individuals with DD/MR throughout the life span; and 4) Provide consultation to community physicians on individuals with DD/MR - e.g., provide a developmental clinic for individuals with DD/MR, particularly those with "dual" diagnosis and on polypharmacy. DDD is also addressing consultative and service relationships with a developmental pediatrician on Maui and autism specialists targeted at enhancing and sustaining its statewide capacity.

DDD is developing a quality assurance system that will use information to trigger immediate action for health and safety concerns, as well as update the Division's strategic plan priorities, goals, activities and allocation of resources. CAMHD will work closely with DDD in assuring oversight of service delivery is adequately addressing the needs of the population. Key is providing oversight for any subcontracted delivery of service, particularly to those youth with intensive need receiving community and residential supports.

Performance Measures

Performance Measures are used in CAMHD to focus the service system on core areas of service provision and supporting infrastructure in order to ultimately achieve timely, cost-effective services that improve the lives of youth served. Measures were selected to organize work around strategic goals, and to promote accountability for results around these goals. Performance measures provide data-driven information that allows for the evaluation of quality and results through objective data.

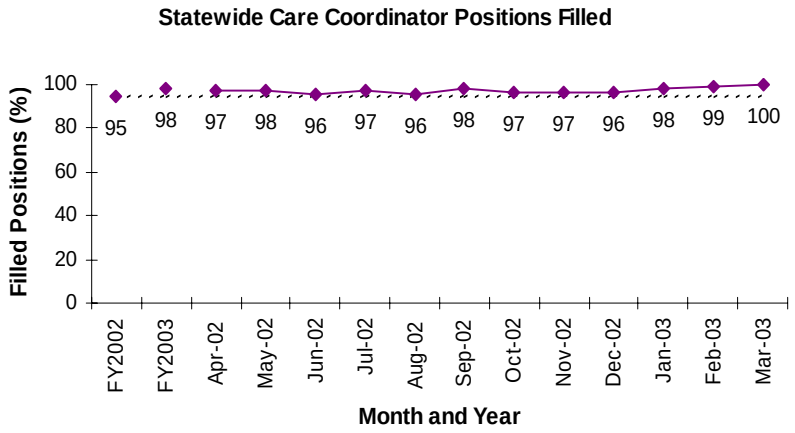
Each of the measures presented below have stated performance goals that meet criteria for demonstrating that CAMHD is sustaining its services, infrastructure, and key practice initiatives at the level needed to maintain gains that have been made since the inception of the Felix Consent Decree and achieve CAMHD practice standards. If baseline performance falls below the established goals CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

CAMHD will maintain sufficient personnel to serve the eligible population.

Goal:

⇨ 95% of mental health care coordinator positions are filled

Over the reporting period, an average of 99% of care coordinator positions statewide were filled, exceeding the goal. At the end of the reporting period (March 2003), all Family Guidance Centers had 100% of positions filled. The trending of this measure gauges stability of the service system over time, and the capacity of the Family Guidance Centers to provide intensive case management services for children and families. The data demonstrates continuing stability in this measure.

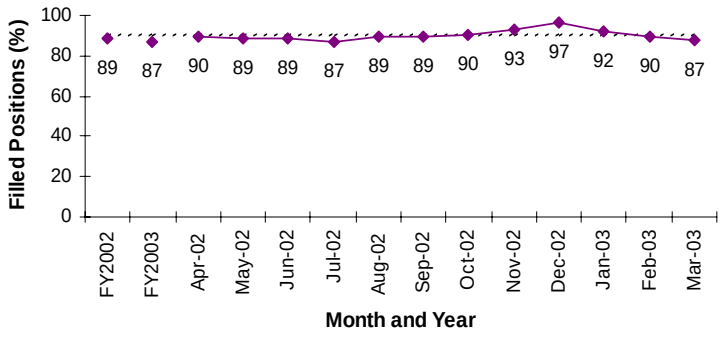


Goal:

⇨ 90% of central administration positions are filled

The performance target was met with an average of 90% of central administration positions filled over the quarter, with a range of 87% to 92% of positions filled. The quarter ended with the percentage slightly below the benchmark, as was the year-to-date average. Central administration positions provide the infrastructure and quality assurance functions necessary to manage the statewide service system. Vacancies were experienced primarily in the Performance Management and Clinical Services Offices. Several of these positions were recently filled.

Statewide Central Administration Positions Filled



Goal:

⇨ 95% of mental health care coordinator caseloads are in the range of 1:15-20 youth

Intensive case management services allow for the needs of children, youth and families to be met through mobilizing, coordinating and maintaining services and resources. The target of 95% of care coordinator caseloads in the range of 15-20 was not met in the quarter because the statewide average caseload was 13. The quarter ended with the statewide average caseload at 14, one case below the performance target. Historically average caseloads were used, but the performance measure was changed to examine the percent of caseloads in the range of 15-20. Adjustments are made to account for FTE assignments for other than full caseloads.

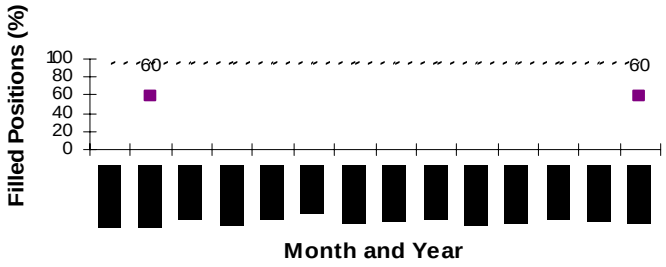
	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
FY02 Average	23	20	11	18	17	15
FY03 Average	12	16	9	13	10	14

Average Caseloads by Family Guidance Center

All of the Family Guidance Centers fell below the range with the exception of Leeward Family Guidance Center. Personnel adjustments have been made in order to assure the most judicious use of this resource. Maui Family Guidance Center, which includes Hana, Lanai, Molokai, continues to fall below the targeted range due to the relatively low numbers of youth with identified intensive mental health issues in these communities coupled with the commitment to provide case management and access to intensive services to youth in remote areas.

The Kauai Family Guidance and the Family Court Liaison Branch data requires computation through an adjusted caseload due to their provision of services to both CAMHD registered youth with intensive mental health needs and youth with less intensive needs. Both these FGCs were below the targeted threshold of caseloads between 15-20. Maui caseloads are also adjusted to account for services to the remote areas.

Statewide Care Coordinators with an FTE Adjusted Caseload of 15-20 excluding Kauai FGC and Family Court Liaison Branch



CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight.

Goal:

⇨ Sustain within quarterly budget allocation

As seen below, in the reporting quarter the total variance from the budget was under projection by $408,000. As such CAMHD sustained within the budget allocation in the quarter.

Variance from Budget (in $1,000's)

	FY 2002 Average	FY 2003 Average	2002.1	2002.2	2002.3	2002.4	2003.1	2003.2
Branch Total	$164	$66	$82	$153	$290	$130	$66	-$195
Services Total	$798	$315	$1,487	-$84	$501	$1,287	$315	$2
Central Office Total	-$189	-$833	-$254	$59	-$535	-$25	-$833	-$216
Grand Total	$773	-$452	$1,315	$128	$256	$1,392	-$452	-$408

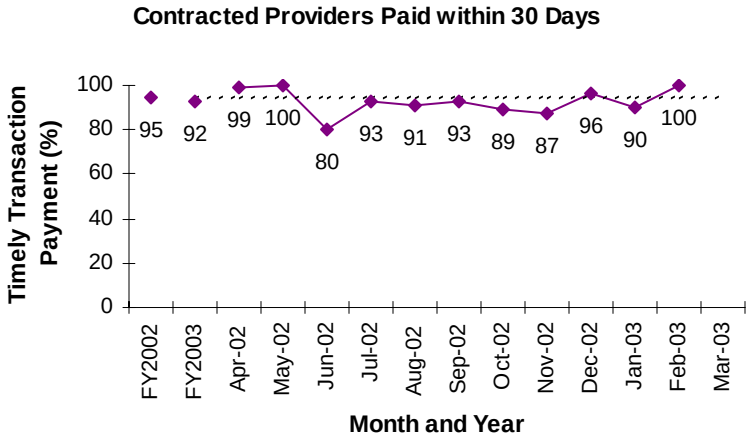
Note: Other services include $8,322,000 encumbered in September, 2002 for HOFGC

CAMHD will maintain timely payment to provider agencies

Goal:

⇨ 95% of contracted providers are paid within 30 days

The target goal was achieved with an average of 95% of payments timely over the two months with available data. Performance on this measure has been fluctuating around the target range with the year-to-date average remaining slightly below the benchmark. The period ended with the strongest performance of the fiscal year.

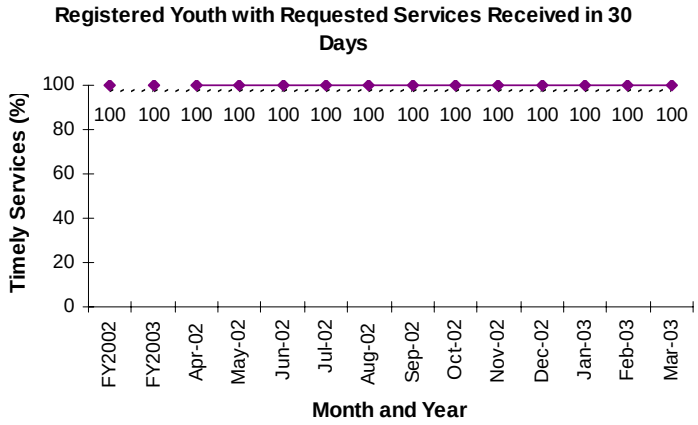


CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ 98% of youth receive services within thirty days of request

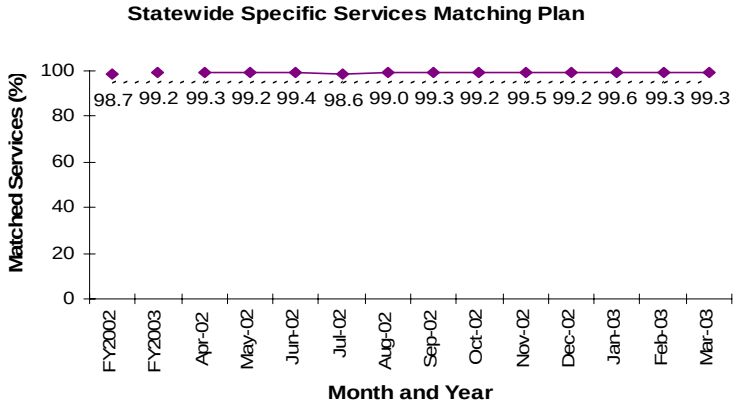
The goal was met for the quarter with 100% of youth receiving services provided timely access to those services. The last reported service gap was in August of 2001.



Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan

CAMHD continued to demonstrate strong performance on this measure. Over 99% of youth in the quarter received the specific services identified by their team plan. In the third quarter, service mismatches occurred in ten complexes. These youth received services, but they were not the exact service prescribed by their IEP teams. Complex data was not available for three youth. Of the ten complexes, two complexes, Campbell and Kau-Keeau-Pahoa had five and three mismatches respectively. The remaining eight complexes had two or fewer mismatches. Campbell was the only complex that had three or more mismatches in both the second and third quarters. The Branch Chief for the FGC is addressing this trend.

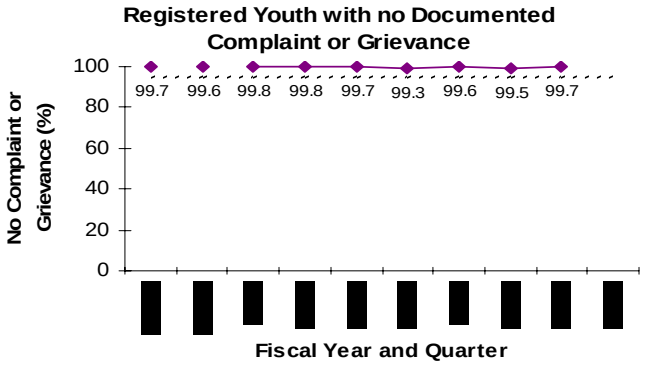


CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received

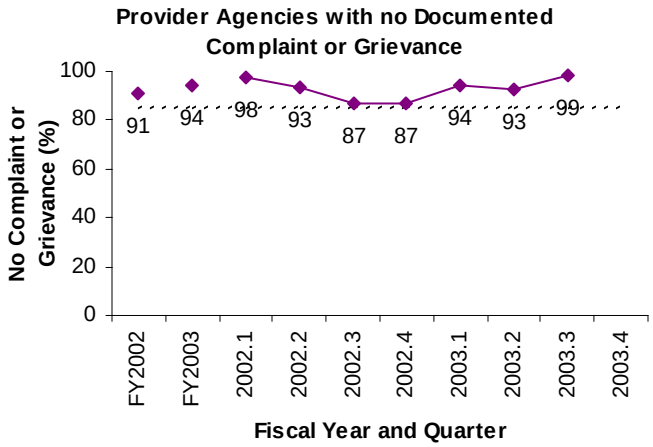
99.7% of youth served in the quarter had no documented complaint received. The target was met across all Family Guidance Centers. There were seven youth with documented complaints representing six complexes: Kealakehe, Baldwin, Maui High, Pahoa, Mililani and Castle. Mililani was the only complex with two complaints represented.



Goal:

➪ 85% of provider agencies have no documented complaint received

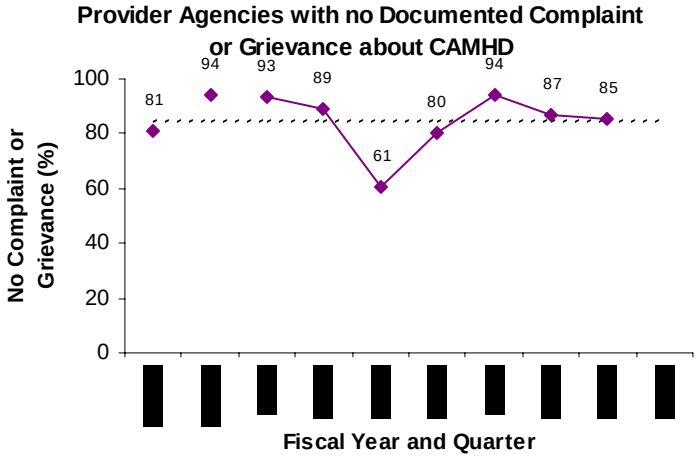
99% of provider agencies had no documented complaint about their services, which exceeded the goal. Performance on this measure has shown an increasing performance trend over the past four quarters and the year-to-date average exceeds the benchmark.



Goal:

➪ 85% of provider agencies will have no documented complaint about CAMHD performance

In the quarter, 85% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. Some fluctuation has been apparent on this indicator, but performance has been above the target for all quarters of this fiscal year.

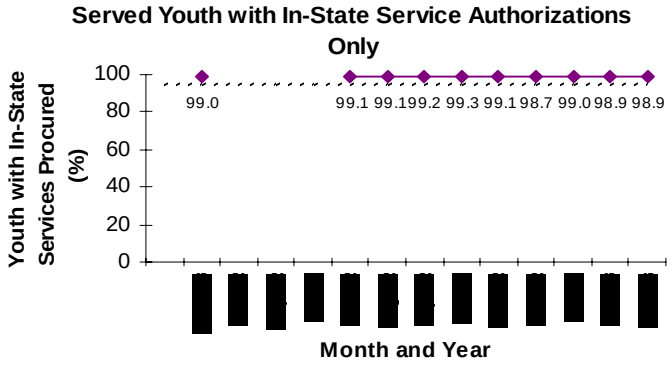


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting.

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii

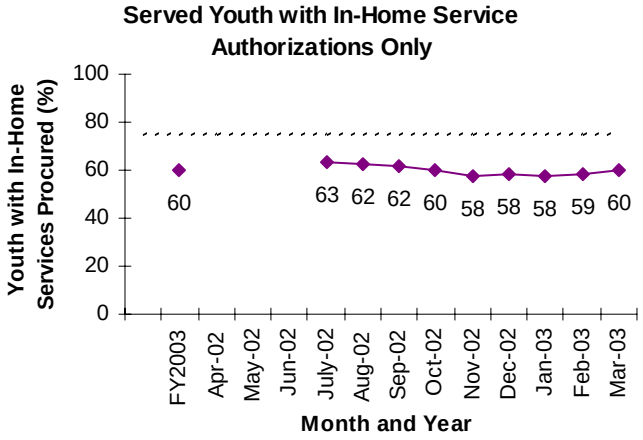
In the quarter, an average of 99% of youth served received treatment within the State, which exceeds the goal. This trend has remained stable over the past year, and is a significant accomplishment for the State of Hawaii in assuring youth receive treatment at home.



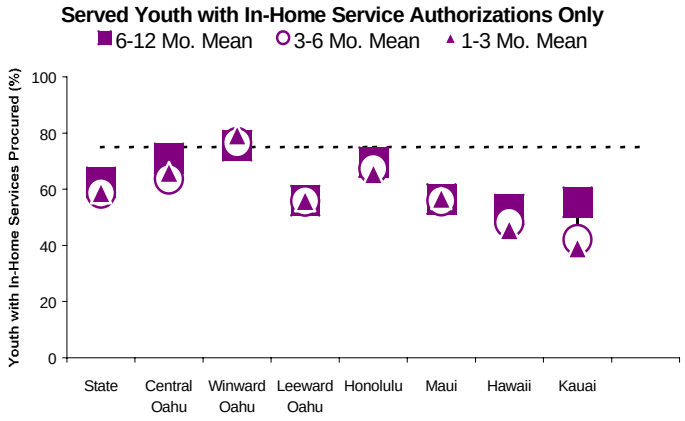
Goal:

⇨ 75% of youth are able to receive treatment while living in their home.

This goal was not fully met as only 59% of youth receiving services in the reporting quarter were receiving treatment while living at home. Significant efforts have been instituted in CAMHD to assure constant clinical review of utilization of any youth receiving treatment in an out-of home setting. The baseline trend for youth receiving services while living in their homes is averaging 60% of the CAMHD population. Although there have been some minor fluctuations in the measure over the year, the period ended at the year to date average. The 75% benchmark was set based on historical data, when CAMHD also served youth with less intensive needs. As the trend is evaluated, there may need to be an adjustment to this benchmark to more realistically align with the service utilization patterns of youth with intensive needs.



There was variability in this measure across communities in the reporting quarter. Windward Family Guidance Center had more positive results than the other Family Guidance Centers in this measure and met the performance goal, serving an average of 79% of their youth in their homes. Central and Honolulu FGC had comparable percentages of youth served in their homes over the quarter (66% and 65% respectively). Maui's average percentage of youth with in-home services was 57% and Leeward's 56%. Of Mokihana's (Kauai Family Guidance Center) small population of youth with intensive mental health needs, 39% were served though intensive home-based services. The trend in each of these areas has been fairly stable since last July, indicating contextual issues may be impacting the measure in each community, but that performance has been relatively stable during the sustainability period. Because CAMHD is committed to preventing out-of home placements unless absolutely necessary for mental health treatment, continual clinical review and team-based planning is a necessary condition of practice and is occurring. Focused analysis of case-review data may help FGC management teams to assess where these practices need strengthening.

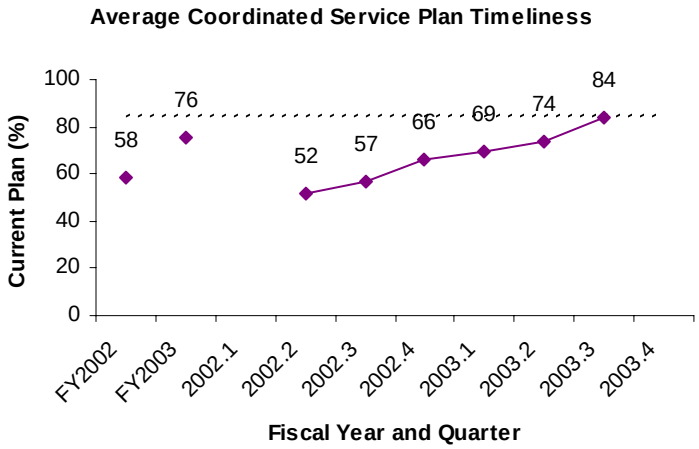


CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

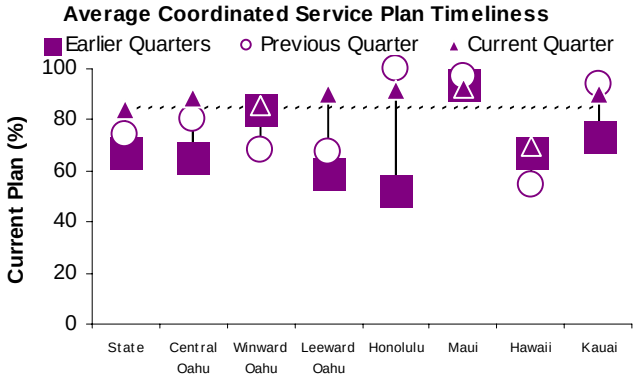
⇨ 85% of youth have a current Coordinated Service Plan (CSP)

There has been considerable improvement in this performance measure since the last report, with strong upward trend. For this reporting quarter (January 1, 2003-March 31, 2003), 84% of youth across the state have a current CSP, defined as having been reviewed at a minimum within the last quarter and adjusted or revised to reflect the child's current situation as often as necessary. This is just short of the performance goal, but demonstrates continuing positive performance in this area.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed

Every Family Guidance Center with the exception of the Big Island (HFGC) met their performance targets for CSP timeliness with 86% to 92% of youth with current CSPs. Because the Big Island has a large registered youth population, the lower performance in this region considerably reduces the overall state average. The data in this quarter also include youth who were newly admitted and have not yet had a CSP developed. This indicates that the service system is assuring a current coordinated plan for virtually every child except a portion of those residing on the Big Island.



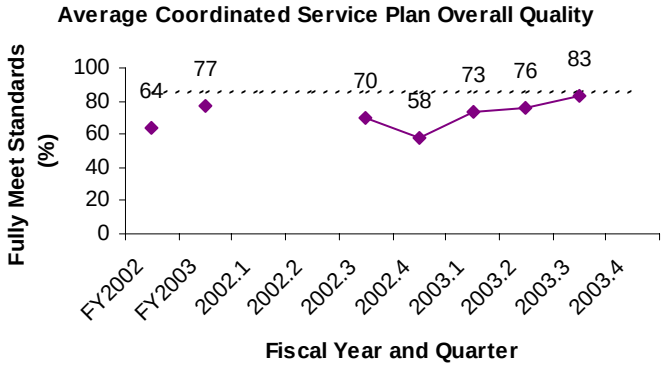
The Hawaii FGC Quality Assurance Committee has conducted a review of factors impacting their ability to meet the goal. Their data analysis suggests that all youth did have a current plan, but not all met the standard of being written, signed and in the child's chart. Incremental improvements have been seen as a result of filling an MHCC vacancy in Waimea and strengthened supervision across all sites. HFGC care coordinators have been historically challenged in engaging families in the CSP process in some areas, and are working more closely with their Parent Partners to engage families.

Goal:

⇨ 85% of Coordinated Service Plan review indicators meet quality standards

Reviews of CSPs against quality standards are conducted quarterly in each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures.

The goal for this measure fell just short of being met in the reporting quarter with 83% of CSPs sampled meeting overall standards for quality. This was an improvement over the last report and considerable improvement over the baseline year (FY2002), when 64% of CSPs met quality standards. Increased efforts to improve the CSP timeliness have also resulted in increases in CSP quality.



There have been improvements across all Family Guidance Centers in facilitating plans that meet quality standards. Central, Maui and Kauai FGC plans are fully meeting standards at levels above performance goals. Honolulu and Windward are making substantial gains in improving the quality of their plans. Hawaii FGC has focused on improving crisis, transition, and discharge plans, addressing focal concerns in plans and assuring a long-term view. Hawaii and Leeward FGCs are continuing to struggle

primarily in the area of engaging child welfare workers, probation officers, and families in the planning process and are working to address the barriers.

There will be a statewide community-based infrastructure to ensure quality service delivery in all communities.

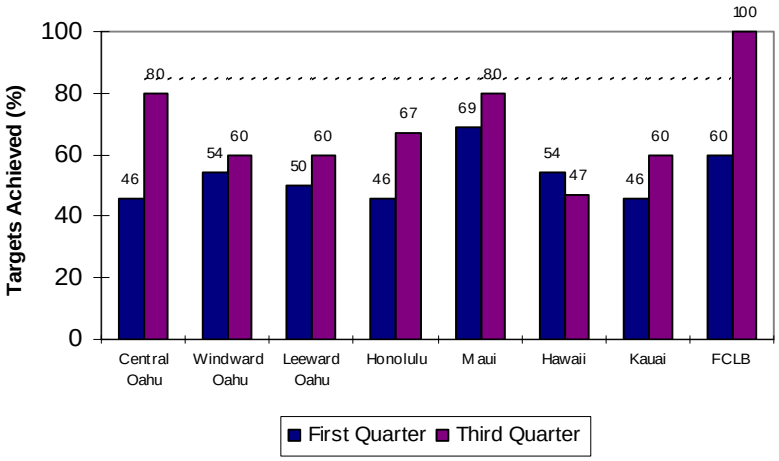
Goal:

⇨ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: expenditures within budget, complaints, access to services, least restrictive environment, timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

The goal of meeting 85% of performance indicators was not met by the FGCs in the reporting quarter, although there has been improvement since the first quarter for all FGCs except the Big Island. On average across all FGCs, 69% of performance goals were met as compared to 55% in the first quarter.

FGC Performance Indicators Successfully Achieved



In general, strengths were demonstrated in the areas of maintaining sufficient personnel, expenditures within fiscal allocations, access to a full array of services, responding to stakeholder concerns, serving youth within the State, assuring current CSPs, performance on Internal Reviews, and impacting child status for youth on outcome measures. There was variable performance in the FGCs in meeting performance targets of quality CSPs, case-based reviews, and family satisfaction. FGCs generally struggled with fully meeting performance goals for maintaining caseloads between 15-20, serving youth while they are living in their homes, and completing tools for measuring child functioning. The measures not achieving goals have been identified as areas for targeted improvements within the FGCs.

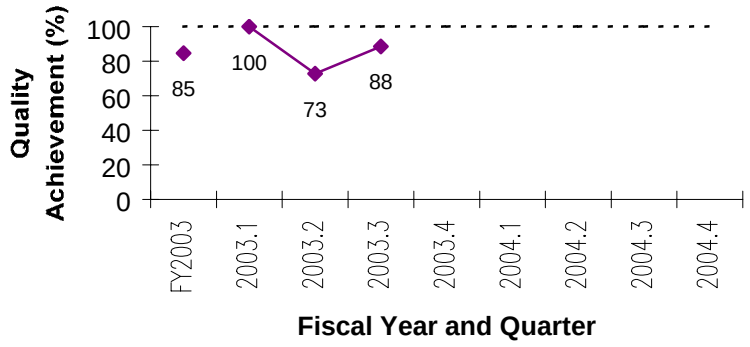
Providing assurances that youth are served in the least restrictive environment and achieving improved functional status are continuing priorities of the CAMHD supervision initiative, including intensive clinical review of each child served on a regular basis.

Goal:

➪ 100% of complexes will maintain acceptable scoring on internal reviews

Acceptable scoring continues to be defined as achieving acceptable system performance for 85% of cases reviewed. The performance goal, which is a joint DOE-DOH measure, is that all complexes will achieve the goal. In the first through third quarters a total of 38 complexes were reviewed. In the second quarter 11 complexes were reviewed, and in the third 25. The statewide trend is displayed below.

Complexes Reviewed during Period that Successfully Achieved Quality Standards on Internal Reviews



Statewide in the quarter, 88% of complexes achieved the performance goal, which did not meeting the performance target. There were six complexes that did not meet the goal: Kahuku (83% acceptable system performance), Hilo (78%), Farrington (78%), Pahoa (69%), Central Kauai (79%), and Nanakuli (64%). All have developed improvement plans and have been scheduled for an internal review early next school year. Further discussion is provided in the Integrated Monitoring Section of this report.

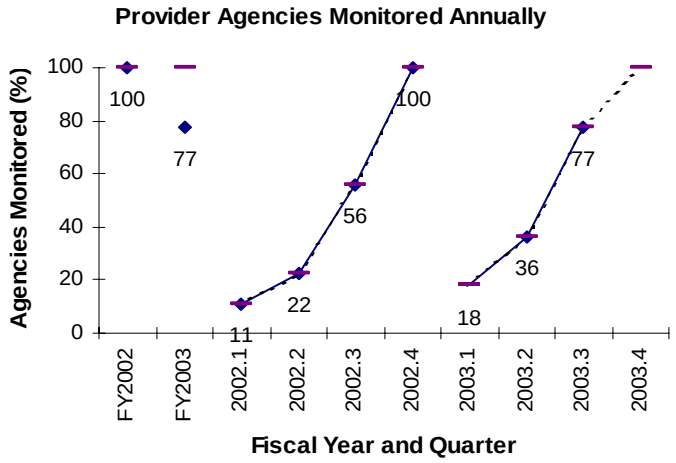
Verification checks are routinely conducted on a sample of cases reviewed to determine if Internal Review findings were consistent with quality standards set for external reviews. Of the 500 cases reviewed, 122 cases or 24% were randomly chosen for a verification check. Of these all but two, or 98.4% were verified as meeting senior reviewers' criteria for a correct determination of findings.

Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually

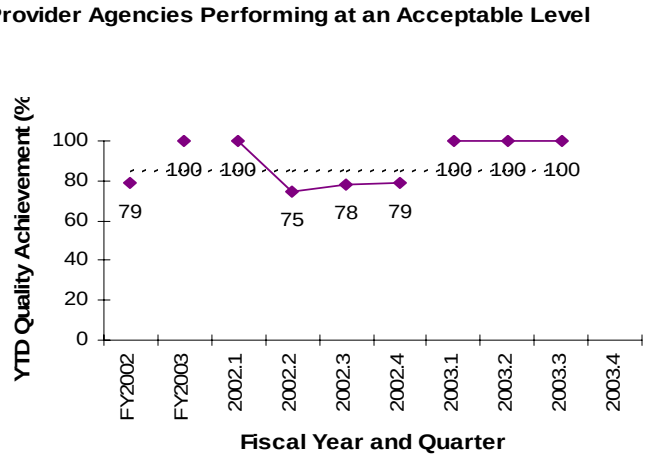
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Programmatic reviews, including case-base reviews, allow for a focused examination of safe and effective practices. Thus far in the fiscal year 2003, 77 % of all agencies have been reviewed. All agencies were reviewed during the scheduled quarter; performance on this measure is meeting its target.



Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, all provider agencies reviewed were found to be performing at an acceptable level, meeting the goal for this measure. Provider agencies are reviewed across multiple dimensions of quality and effective practices.

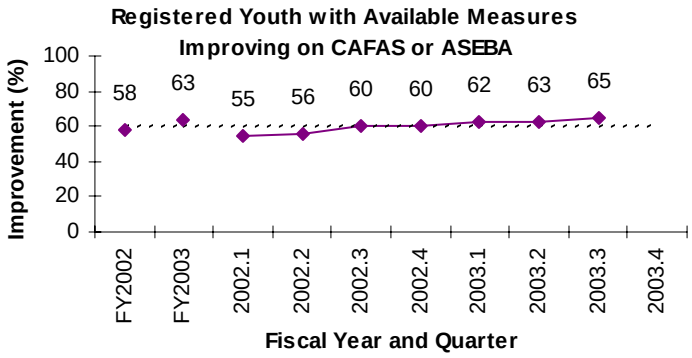


CAMHD will demonstrate improvements in child status

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)

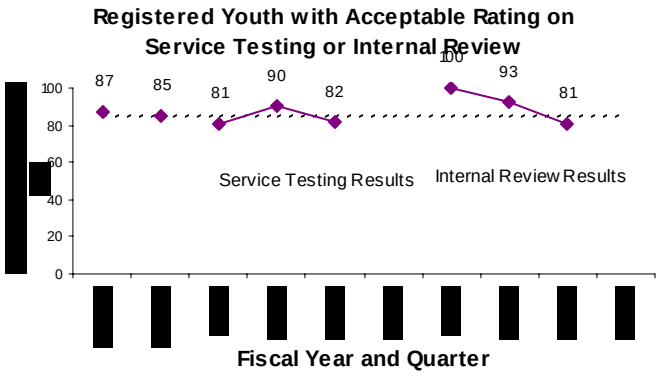
To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to complete the CAFAS and Achenbach (ASEBA) for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%. In the reporting quarter, for youth with data for these measures, 65% of youth were showing improvements since entering the CAMHD system, which meets the performance goal. This indicator has demonstrated a slow, steady improvement since its inception, and ended the period at an all-time high.



Goal:

⇨ 85% of those with case-based reviews show acceptable child status

In the third quarter 81% had acceptable child status, which was short of the performance goal.



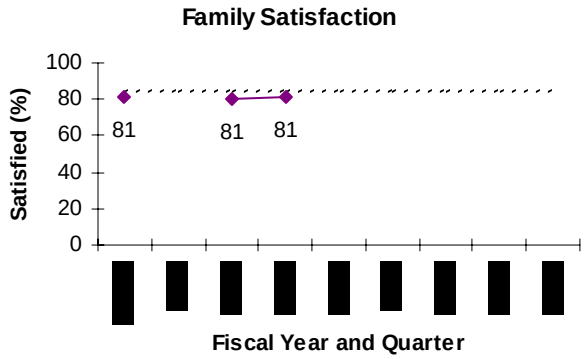
The year to date average of 85% of youth demonstrating acceptable status meets the performance target. However, consistent with the system performance measure, internal reviews are suggesting some decrease in child status. Of the 539 cases reviewed statewide (including those care coordinated by DOE), seventeen of the youth with services care coordinated through the Family Guidance Centers (3% of those reviewed) had unacceptable child status, and of these five also had unacceptable system performance. Each respective FGC clinical teams will review these cases and determine what changes need to be made to care or treatment.

Families will be engaged as partners in the planning process

Goal:

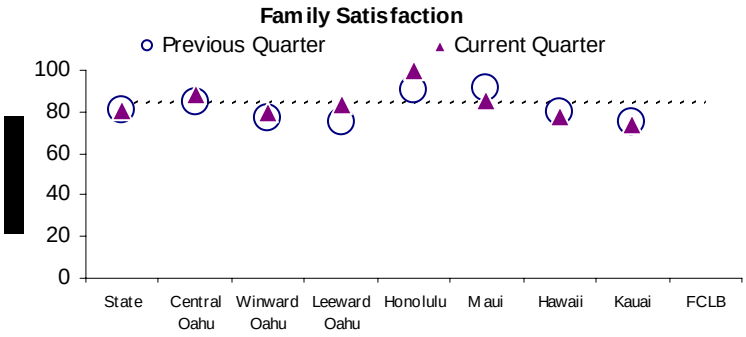
⇨ 85% of families surveyed report satisfaction with CAMHD services

Family and youth satisfaction information is collected through the CAMHD family organization partner, Hawaii Families as Allies. This is a significant advancement in the delivery mechanism for obtaining information on consumer satisfaction. The obtained samples for the caregiver satisfaction survey have approximated the target sample size of 10% of the registered population each quarter (i.e., 9.4% and 7.6% respectively). However, the youth survey has not yet achieved sufficient sampling to merit reporting (i.e., 1.1% and 0.6% respectively). As seen below, 81% of families surveyed were satisfied with services received in the reporting quarter. This was somewhat short of the performance target for the State, and will provide the baseline for future quarters. Performance was stable during the past two quarter.



Displayed below are the Family Satisfaction results for the FGCs. As seen, family satisfaction varied by FGC from 74% of families satisfied overall with services on Kauai, to 100% of those surveyed in the Honolulu District satisfied. It is important to note that the sample sizes within each quarter are small, so that these estimates are less reliable and the mean satisfaction

across quarters (e.g., the midpoint between the circle and the triangle) should provide a somewhat more reliable indicator.



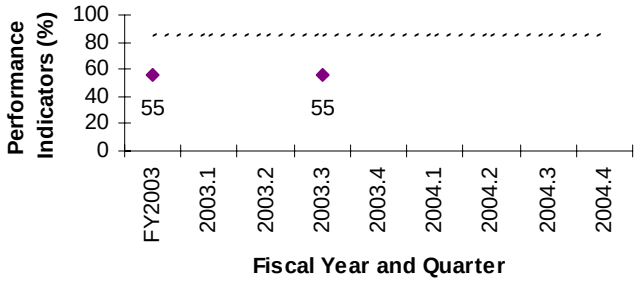
There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section under the Clinical Services, Performance Management and Administrative Offices as an accountability and planning tool. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team, and are reported monthly. A total of thirty-five measures are tracked. Performance results and trends are discussed and strategies are developed to sustain or improve performance. In the reporting quarter, 55% of measures were successfully met. This was the first quarter that sufficient measurement systems were operational, so this estimate will provide the baseline for future quarters.

Central Office Performance Indicators Successfully Achieved

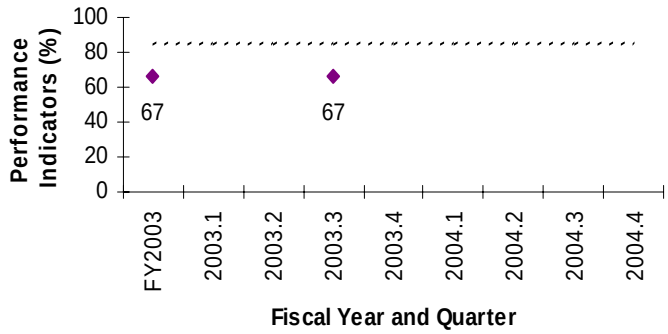


Goal:

➪ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of thirteen measures are tracked and reported on in the monthly meeting. In the quarter 67% of performance goals were met through the work of the CAMHD Committees. Again, this was the first time measurements were fully operational, so this estimate provides a baseline for committee performance.

Committee Performance Indicators Successfully Achieved



Summary

The majority of performance goals were met or exceeded in the third quarter. The areas of strength included all measures of sustainability regarding maintenance of infrastructure, funding, timely access to services, system responsiveness to stakeholder concerns, and quality service provision

The following were measures that met or exceeded goals:

- Filled care coordinator and central office positions
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Timely access to services
- Timely and effective response to stakeholder concerns
- Youth receiving treatment within the State of Hawaii
- Family Court Liaison Branch performance goals
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA

All of the above measures were meeting or exceeding goals in both the first and third quarters with the exception of improvements in child status as measured through the CAFAS or ASEBA, which is meeting goals as of this reporting quarter.

The following measures demonstrated a strong or improving trends, but are not yet achieving the targeted goal:

- Coordinated Service Plan timeliness and quality
- Family Guidance Center performance indicators
- Completion of CAFAS and ASEBA measures

The most significant gains have been made across the state in assuring current and quality Coordinated Service Plans. Improvements that have been implemented, including managing meeting logistics and supervision, have had an impact on performance. Renewed discussions are occurring at the leadership level regarding the function of the CSP with the goal of strengthening and clarifying the CSP process.

The following measures had new or revised measurement systems implemented and a below-targeted performance:

- Caseloads within the range of 1:15-20 youth
- Family Satisfaction
- Central Office performance indicators

Caseloads within the 1:15-20 range are being adjusted throughout the system by determining need within each FGC. Family satisfaction data will be presented to PISC for discussion and development of strategies that will impact family satisfaction. Likewise, all indicators used to impact performance at the Central Office are routinely examined at PISC and by management to develop actions that will impact the trends.

There was one measure that demonstrated stable performance but continued to be below benchmark. This measure is:

- Youth receiving treatment while living in their homes

As discussed in earlier text, commitment to CASSP principals and serving youth in the least restrictive environment dictates constant work in assuring out of home services are used only when absolutely necessary. The growing evidence in children's mental health supports the lack of benefit in placing youth in institutional care, and the need to redirect team efforts toward home and community-based interventions. Dissemination and training on effective treatments will be intensified over the next quarter. CAMHD's supervision and utilization review initiatives will be key recipients of training. This will be coupled with a renewed engagement with providers to assure treatment and supports are given at the intensity needed to prevent out of home placements, or to support the appropriate return of youth to their homes and communities.

There were two measures identified with a declining trend:

- Complexes maintaining acceptable scoring on internal reviews
- Child status on internal reviews

Improvement plans for each of the six complexes performing below the performance goals have been developed and reviewed by State-level personnel. These complexes are implementing plans, and will be reviewed again early in Fall of 2003. The percentage of youth reviewed with acceptable child status was 81%, which is just below the benchmark. This trend will be carefully monitored and reviews of any youth with unacceptable child status will occur as discussed earlier.

Overall in the reporting period, CAMHD continued to demonstrate sustainability of services and service-delivery infrastructure. For the areas not at the desired level of performance, each of the focused improvements that have been recommended will be discussed by management and the CAMHD Performance Improvement Steering Committee in order to impact full benefit of services for youth and their families.